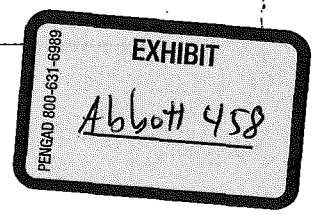
EXHIBIT 48

United States General Accounting Office

GAO

Fact Sheet for Congressional Committees



March 1993

MEDICAID

Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland

GAO/HRD-93-55FS

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-251918

March 18, 1993

The Honorable Daniel P. Moynihan, Chairman
The Honorable Bob Packwood, Ranking Minority Member
Committee on Finance
United States Senate

The Honorable David Pryor, Chairman
The Honorable William S. Cohen, Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable John D. Dingell, Chairman
The Honorable Carlos J. Moorhead, Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Omnibus Budget Reconciliation Act of 1990 (OBRA) included provisions intended to reduce the costs of outpatient prescription drugs[1] paid by state Medicaid programs.[2] Other OBRA provisions indicated the interest of the Congress in identifying additional areas where potential Medicaid cost savings for prescription drugs might be realized. One such provision required GAO to conduct a study of drug purchasing and billing practices of hospitals, other institutional facilities, health maintenance organizations (HMO), and retail pharmacies. To comply with this requirement, we determined the extent to which select pharmacies that purchase outpatient drugs at a discount from drug manufacturers pass on any of the savings to state Medicaid programs. Members of Congress were concerned that many pharmacies that dispensed prescriptions for Medicaid recipients routinely purchased outpatient drugs at substantially discounted prices but did not pass on any of the savings to Medicaid.

We compared drug purchase costs and Medicaid reimbursements in two states—Illinois and Maryland. We selected these states because each uses one of two basic formulas used by states to reimburse pharmacies' drug purchase costs and both states have relatively high expenditures for outpatient drug prescriptions. In each state, we compared the prices that

[1]These are drugs that can be dispensed on an outpatient basis to ambulatory patients, typically as capsules or tablets. In contrast, inpatient drugs are typically injectable drugs that are administered by intramuscular or intravenous injections.

[2]Medicaid was established in 1966 as a means-tested entitlement program of medical assistance for certain low-income people. Eligibility and coverage standards are determined by the states within broad federal requirements. Coverage of outpatient prescription drugs is an optional Medicaid service provided by all states and the District of Columbia.

selected hospital outpatient and nursing home pharmacies[3] paid for specific outpatient drugs to the Medicaid reimbursements the pharmacies received. Because our study compared purchase prices to Medicaid reimbursements, it did not include the pharmacies' costs to dispense specific drugs or the states' reimbursements for dispensing costs. We also compared the prices the pharmacies paid to the drugs' average wholesale prices (AWP).[4] AWP represents the price pharmacies would pay if they did not receive discounts from manufacturers.[5]

The results of this study cannot be projected statewide or nationally. Because the study included selected pharmacies, differences between drug purchase costs and reimbursements may vary for other pharmacies in each state. Further, because reimbursement formulas vary by state, differences between drug purchase costs and reimbursements may vary elsewhere from our results in Illinois and Maryland.

Background

In fiscal year 1991, Medicaid programs spent an estimated $5.5 billion for outpatient prescription drugs—about 7 percent of total Medicaid expenditures. States reimburse most outpatient pharmacies per prescription dispensed with the amount of reimbursement varying by drug. Each state has the authority to develop its own reimbursement formula for prescription drugs, subject to upper payment limits established by the Health Care Financing Administration (HCFA). Because pharmacies routinely receive a discount off a drug's AWP, HCFA requires states to develop formulas that reimburse pharmacies at prices below AWP. A pharmacy's purchase price for a drug includes the price the pharmacy paid the manufacturer for the drug plus any wholesaler markup. Each state also pays pharmacies a professional dispensing fee for each prescription. The dispensing fee is intended to cover the pharmacy's labor and overhead costs, such as pharmacists' salaries, drug packaging, rent, and utilities. Each state develops its own method for calculating dispensing fees. (See app. I for information on the reimbursement formulas and dispensing fees.)

[3]Referred to as nursing home consultant pharmacies, these nonretail pharmacies contract with nursing homes to exclusively dispense prescription drugs to patients and provide nursing homes other consultant services, such as review of patient drug therapies. Nursing home patients have the option of purchasing their drugs through this type of service or from retail pharmacies.

[4]Drug manufacturers suggest a list price that wholesalers charge pharmacies. The average of the list prices, collected from many wholesalers, is a drug's AWP.

[5]A discount here is the percentage difference between the price a pharmacy pays for a drug and its AWP.

Before OBRA, state Medicaid programs used several approaches to contain Medicaid drug costs, including reducing pharmacy reimbursements. There was concern that this strategy could cause many retail pharmacies to drop out of the Medicaid program. Therefore, through OBRA, the Congress imposed a 4-year moratorium on reducing pharmacy reimbursement levels. Specifically, OBRA prohibited HCFA or the states from reducing reimbursement limits for outpatient prescription drugs or dispensing fees for such drugs until 1995.

Historically, hospital outpatient and nursing home pharmacies have paid discounted prices for outpatient drugs. Although pharmacies use different strategies to obtain such prices, one strategy shared by hospital and nursing home pharmacies is to have a group purchasing organization (GPO) represent them in negotiating with drug manufacturers. A single GPO may represent hundreds of institutions, including hospital pharmacies, health maintenance organizations (HMO), and nursing home pharmacies. Because the institutions collectively represent a considerable percentage of the market for a drug manufacturer's product, the GPO is able to obtain substantially discounted prices from the manufacturer. Eight of the nine pharmacies in our study were represented by GPOs.

Scope and Methodology

Our study focused on the purchase and reimbursement of outpatient drugs at hospital outpatient and nursing home pharmacies for two reasons.[6] First, as previously noted, manufacturers have historically given hospital and nursing home pharmacies large drug price discounts. As a result, both types of pharmacies may pay much lower prices for some drugs than what they receive in reimbursements from Medicaid. Second, hospital outpatient and nursing home pharmacies bill Medicaid on a per prescription basis that enabled us to obtain reimbursement amounts for specific drugs from the state Medicaid programs.

We selected a total of 10 pharmacies—5 in Illinois and 5 in Maryland[7] —that according to state officials dispensed large volumes of Medicaid prescriptions. To determine how the Medicaid programs in

[6]Although OBRA also required that we include HMOs in our study, we excluded them because they do not bill Medicaid per prescription. As a result, HMO reimbursement amounts for specific drugs were not available from state Medicaid programs.

[7]Our final analysis includes nine pharmacies. We excluded one Maryland hospital outpatient pharmacy from our final analysis after pharmacy officials told us that there were errors in their billing process. Because of these errors, the pharmacy's billing process did not accurately reflect the pharmacy's drug purchase cost. As a result, the pharmacy billed Medicaid less than its purchase costs during the period of our study.

Illinois and Maryland reimburse pharmacies for prescription drugs, we interviewed HCFA headquarters and regional officials and state Medicaid officials.

To determine the differences between what the pharmacies were reimbursed by Medicaid for outpatient drugs and what they paid required several steps. First, in each state we obtained a list of the 50 outpatient drugs for which the state Medicaid program reimbursed the most prescriptions.[8] Between the two states, this resulted in 75 different drugs (see apps. II and III). Second, we compared the drugs on each state list with state Medicaid reimbursement data for each pharmacy. We did this to determine which drugs on the state list were also drugs for which each pharmacy received Medicaid reimbursement in October 1991. Third, for each drug that Medicaid reimbursed a prescription, we determined how much the pharmacy was reimbursed per unit, such as per tablet or capsule. The per unit price does not reflect the payment that each pharmacy received for professional dispensing fees. Fourth, we determined what the pharmacy paid per unit by reviewing each pharmacy's invoices and contracts. We then determined the percentage difference between the drug reimbursement and purchase price for each drug.

To determine the extent to which each pharmacy received price discounts for the drugs we reviewed, we compared the price the pharmacy paid for a drug to the drug's AWP for August 1991. We obtained AWP data from Medi-Span, one of several national databases that provide a history of AWP prices for individual drugs.

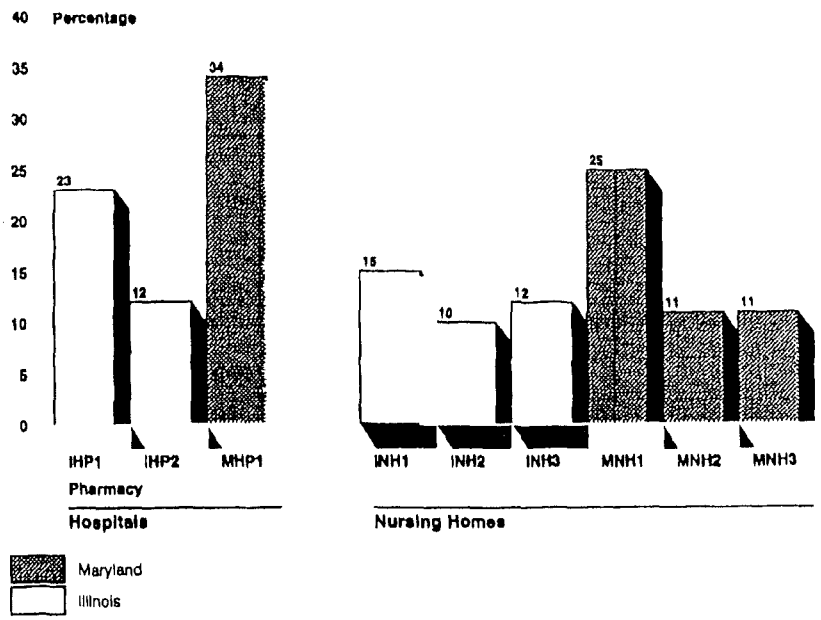
Our work was performed between December 1991 and October 1992 in accordance with generally accepted government auditing standards.

Summary

The nine pharmacies in Illinois and Maryland received total Medicaid reimbursements for the drugs we studied that were about 19 percent more than the total amount they paid. For the Illinois pharmacies, the amount by which reimbursements exceeded purchase costs ranged from 10 to 23 percent. For the Maryland pharmacies, the range was from 11 to 34 percent.

[8]The Illinois list was based on data for November 1, 1990 to October 31, 1991; Maryland's list was based on data for its fiscal year 1991 (July 1, 1990 to June 30, 1991).

Figure 1: Percentage That Medicaid Reimbursements Exceeded Drug Purchase Costs for Nine Pharmacies



Note: Illinois hospital and nursing home pharmacies are designated as IHP and INH; Maryland pharmacies are designated MHP and MNH.

Figure 1 shows that the range by which reimbursements exceeded purchase costs for the individual pharmacies was considerable. However, the average amount by which reimbursements exceeded purchase costs was higher for the hospital pharmacies than for the nursing homes pharmacies. For the hospital pharmacies, the average was about 23 percent, compared to about 13 percent for the nursing home pharmacies. The hospital pharmacies realized a higher average because they generally paid lower prices for drugs than the nursing home pharmacies.

All nine pharmacies purchased drugs at prices below AWP. The pharmacies paid an average 26 percent less than AWP for the drugs we reviewed. Hospital pharmacies paid an average 30 percent less than AWP, while nursing home pharmacies paid an average 21 percent less than AWP. The purchase prices for the nine pharmacies ranged from 16 to 42 percent less

than AWP. According to industry experts, retail pharmacies routinely pay prices that average about 13 percent less than AWP.

Although total Medicaid reimbursements exceeded the pharmacies' total drug purchase costs for the drugs we reviewed, whether this represents unreasonable benefits for the pharmacies is not clear. Neither HCFA nor the states have determined what would be an appropriate margin between reimbursements and costs. Further, representatives of all nine pharmacies contended that because of insufficient dispensing fees they used the excess reimbursements to cover the drugs' dispensing costs. Only one of the nine pharmacies provided us an estimate of what it considered its average dispensing cost.[9]

From 1976 to 1987, HCFA required states to periodically conduct surveys to gather data on pharmacies' dispensing costs so that they could be used by the states to set dispensing fees. However, in 1987, HCFA rescinded this requirement when it became clear that most states were not conducting the surveys. Because of fiscal constraints and competing budget priorities, HCFA officials noted that states considered the surveys too expensive. HCFA officials also noted that because states focused on reducing Medicaid costs, most state programs were not willing to increase dispensing fees regardless of survey results. HCFA now allows each state to develop dispensing fees based on whatever methods or factors the state chooses to use.

HCFA and state Medicaid officials agreed that pharmacies must often use excess Medicaid reimbursements to cover their dispensing costs. However, because the officials did not have current data on dispensing costs, they did not know what dispensing fees should be.

Because of the issues raised by pharmacy representatives and Medicaid officials about the sufficiency of dispensing fees and the lack of current data concerning such fees, we do not know the extent to which reimbursements in excess of drug purchase costs represent a potential source for Medicaid savings in the two states studied. This will remain unclear until new data are collected on pharmacies' actual dispensing costs. With this information, HCFA and the states could more realistically assess the potential to change reimbursement policies to achieve Medicaid savings. However, because of the 4-year moratorium on reducing

[9]The pharmacy's average dispensing fee per prescription for October 1991 was $4.63. The pharmacy estimated, however, that its average dispensing cost per prescription for all payers was $12.27. The estimate included $3.58 for direct costs, such as pharmacists' salaries and drug packaging, and $8.69 for indirect costs, such as time spent purchasing drugs and billing the state for reimbursement.

reimbursement limits for outpatient prescription drugs and dispensing fees, HCFA headquarters and state Medicaid officials did not believe that surveys of dispensing costs or the evaluation of the appropriateness of state reimbursement policies would be appropriate at this time.

We discussed this information with HCFA headquarters and regional officials as well as Illinois and Maryland Medicaid officials. Their comments have been incorporated as appropriate. We are sending copies of this fact sheet to the Secretary of Health and Human Services; the Administrator, Health Care Financing Administration; the Director, Office of Management and Budget; and other interested parties. Copies will be made available to others upon request.

Should you have any questions concerning this report, please contact me at (202) 512-7119. Other major contributors are listed in appendix IV.

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Contents

Abbreviations

AWP	average wholesale price
EAC	estimated acquisition cost
GPO	group purchasing organization
HCFA	Health Care Financing Administration
HMO	health maintenance organization
OBRA	Omnibus Budget Reconciliation Act of 1990
UD	unit dose
WAC	wholesale acquisition cost

Medicaid Reimbursement and Billing

Federal regulations covering Medicaid reimbursement for outpatient prescription drugs (42 C.F.R. 447.331-.334) allow state Medicaid programs to develop formulas to reimburse pharmacies for the purchase costs of drugs, subject to HCFA upper limits. The regulations also allow state programs to pay pharmacies a fee to cover the costs of dispensing each prescription.

HCFA sets reimbursement upper limits for certain multiple-source drugs. These are drugs that the Food and Drug Administration has evaluated as having generic equivalents to the brand name drug and have at least three suppliers who sell the drug nationally. HCFA sets the reimbursement limits using a compendia of national cost information. HCFA's 1990 list of these multiple-source drugs includes about 400 drugs. For each of these 400 drugs, Medicaid will only pay a pharmacy the HCFA listed price, unless the prescribing doctor certifies in writing that a specific brand name is medically necessary. Of the 75 drugs we reviewed, only 7 were multiple-source drugs subject to this limit.

For all other drugs, HCFA requires states to develop reimbursement formulas that pay a significant discount off the average wholesale price (AWP). HCFA based this policy on evidence that indicated that pharmacies purchased drugs at prices that were, on average, about 16 percent below AWP.[1] However, HCFA did not recommend a specific percentage off AWP for states to consider. Each state estimates what it costs a pharmacy to purchase a drug and bases its formula on this estimated acquisition cost (EAC).[2] HCFA refers to each state upper limit as the EAC.

Illinois and Maryland use different EAC reimbursement formulas for outpatient prescription drugs dispensed to Medicaid recipients. Illinois reimburses pharmacies up to the drug's AWP minus 10 percent.[3] The dispensing fee ranges from $3.58 to $15.00, depending upon the dollar value of the prescription. Maryland reimburses pharmacies up to the wholesale acquisition cost (WAC), the discounted price wholesalers charge

[1]Use of Average Wholesale Prices in Reimbursing Pharmacies Participating in Medicaid and the Medicare Prescription Drug Program, Department of Health and Human Services, Office of Inspector General, Office of Audit, October 3, 1989.

[2]Most states base their reimbursement formulas on AWP less a percentage that ranges from 5 to 11 percent.

[3]Illinois obtains AWP prices from the American Druggists' Bluebook.

pharmacies, plus 10 percent.[4] Maryland's dispensing fee ranges from $4.94 to $6.17, depending upon the dollar value of the prescription.

Maryland Medicaid officials said that the state's reimbursement formula is based on WAC instead of AWP because they believe that WAC can more closely approximate the price hospital and nursing home pharmacies actually pay for a drug. The officials believe this because (1) WAC is based on the price manufacturers charge wholesalers and is, therefore, normally less than AWP—the estimated price wholesalers charge pharmacies, and (2) hospital and nursing home pharmacies routinely receive significant discounts off AWP.[5]

To receive reimbursement for most of the drugs we reviewed, a pharmacy must bill the state Medicaid program its usual and customary charge—the price they charge the general public. For the two states we reviewed, the amount that a pharmacy bills Medicaid includes both the charge for the drug and the dispensing fee. If a pharmacy's usual and customary charge is above the EAC, Medicaid will only pay the EAC. If a pharmacy's usual and customary charge is below the EAC, Medicaid will reimburse the lower amount.

For the prescriptions we reviewed, the nursing home pharmacies more frequently billed Medicaid higher usual and customary charges than did the hospital outpatient pharmacies. The Illinois nursing home pharmacies billed Medicaid at or above the state's EAC for 53 percent of the prescriptions we reviewed, while the Maryland nursing home pharmacies billed Medicaid at or above the state's EAC for 81 percent of the prescriptions we reviewed. In contrast, the Illinois hospital outpatient pharmacies billed Medicaid at or above the state's EAC for about 41 percent of the prescriptions we reviewed. In Maryland, the hospital pharmacy billed at or above the state EAC for 54 percent of the prescriptions we reviewed.

[4]Four states, including Maryland, use a formula based on WAC plus a percentage that ranges from 7 to 10 percent.

[5]Maryland obtains WAC prices from First Data Bank, a national database.

Appendix II

Drug Purchase Prices for Illinois Pharmacies

The following table shows the prices that each of the five pharmacies—two hospital outpatient pharmacies (IHP 1 and 2) and three nursing home pharmacies (INH 1, 2, and 3)—paid per unit for those drugs on the state Medicaid program's top-50 list of outpatient drugs for the year ending October 31, 1991. For oral solids, unit prices are listed by tablet, capsule, or pack. For other products, such as inhalers or insulin, the unit price is for the most frequently dispensed size, as indicated. The top-50 drugs are those for which the state Medicaid program reimbursed the most number of prescriptions. The table also shows each drug's average wholesale price (AWP), as reported on Medi-Span for August 1991.

	Product/unit	IHP1	IHP2	INH1	INH2	INH3	AWP
1.	Zantac 150mg/tab	$0.85	$0.86	$1.18	$1.22	$1.19	$1.40
2.	Insulin needle	[a]	[a]	[a]	[a]	[a]	[a]
3.	Diphenhydramine HCL 12.5mg 5ml/120ml	0.46	[a]	0.30	[a]	0.71	1.03
4.	Dilantin-extended release 100mg/cap	0.12	0.12	0.08	0.12	0.08	0.14
5.	Ortho-novum 777/pack-28 tabs	0.35	0.00[b]	[a]	[a]	[a]	[c]
6.	Amoxicillin 250mg 5cc/150cc	2.04	[a]	2.26	2.24	2.48	5.98
7.	Amoxicillin 125mg 5cc/150cc	1.18	[a]	[a]	[a]	[a]	3.48
8.	Acetaminophen 80mg .8ml/15ml	0.46	[a]	[a]	[a]	[a]	[c]
9.	Tri-phasil/pack-28 tabs	1.01	[a]	[a]	[a]	[a]	[c]
10.	Prozac 20mg/cap	1.54	1.54	1.53	1.54	1.55	1.83
11.	Albuterol sulfate syrup 2mg 5ml/30ml	1.05	[a]	[a]	[a]	1.02	1.74
12.	Tagamet 400mg/tab	0.95	0.96	0.97	0.99	0.97	1.12
13.	Micronase, Diabeta 5mg/tab	0.15	0.34	0.21	0.24	0.27	0.37
14.	Vasotec 5mg/tab	0.64	0.64	0.64	0.66	0.64	0.80
15.	K-Dur 20meq/tab	0.02	[a]	0.19[d]	0.17	0.17	0.29
16.	Vasotec 10mg/tab	0.67	0.68	0.67	[a]	[a]	0.84
17.	Trental 400mg/tab	0.35	[a]	0.33[d]	0.34	0.30[d]	0.41
18.	Procardia XL 30mg/tab	0.89	0.85	0.84	[a]	0.84	1.05
19.	Tagamet 300mg/tab	0.57	[a]	0.57	[a]	0.58	0.67
20.	Amoxicillin 125mg 5cc/100cc	[a]	[a]	[a]	[a]	[a]	[a]
21.	Resol oral electrolyte/960ml	3.91	[a]	[a]	[a]	[a]	[c]
22.	Lanoxin 0.125mg/tab	0.06	0.06	0.06[d]	0.06	0.06	0.07
23.	Procardia XL 60mg/tab	1.60	1.53	[a]	[a]	1.51	1.89
24.	Phenytoin prompt release 100mg/cap	[a]	[a]	[a]	[a]	[a]	[a]
25.	Iletin I NPH/10ml	[a]	6.82	[a]	[a]	[a]	12.68
26.	Nix creme rinse 1%/60ml	5.81	[a]	[a]	[a]	[a]	6.89
27.	Atrovent inhaler/14gm	17.40	18.05	[a]	[a]	14.14	21.44

(continued)

Appendix II
Drug Purchase Prices for Illinois Pharmacies

Product/unit	IHP1	IHP2	INH1	INH2	INH3	AWP
28. Terconazole cream 0.4%/45gm	[a]	6.31	[a]	[a]	[a]	19.10
29. Mevacor 20mg/tab	1.47	[a]	1.47	1.53	1.47	1.84
30. Lo-Ovral/pack-28 tabs	1.76	1.75	[a]	[a]	[a]	21.36
31 Amoxicillin 250mg 5cc/100cc	[a]	[a]	[a]	[a]	[a]	[a]
32. Capoten 25mg/tab	0.42	0.46	0.47	0.47	0.47	0.57
33. Tenormin 50mg/tab	0.62	0.65	0.57	0.64	0.56	0.78
34. Insulin U-100 human/10ml	[a]	[a]	[a]	[a]	[a]	[a]
35 Capoten 12.5mg/tab	0.38	0.42	0.43	0.43	0.43	0.52
36. Halcion 0.25mg/tab	0.48	0.48	[a]	0.45	0.42	0.60
37. Albuterol sulfate sol/20ml	8.93	[a]	[a]	[a]	8.71	14.86
38. Glucofilm test strips/per 50	0.52	0.58	[a]	[a]	[a]	0.66
39. Carafate 1gm/tab	0.49	[a]	[a]	0.48	0.47	0.61
40. Naproxen sodium 550mg/tab	[a]	0.85	[a]	[a]	0.86	1.05
41 Premarin 0.625mg/tab	0.24	0.19	[a]	[a]	[a]	0.32
42. Actiderm dermatological patch	[a]	[a]	[a]	[a]	[a]	[a]
43. Diflunisal 500mg/tab	0.83	[a]	[a]	[a]	[a]	1.04
44 Lotrisone cream/15gm	[a]	[a]	[a]	8.74	5.40	9.14
45. Buspar 10mg/tab	[a]	[a]	[a]	0.66	0.66	0.83
46. Micronase, Diabeta 2.5mg/tab	0.09	[a]	0.20[d]	0.13	0.16	0.24
47. Beconase nasal spray/25gm	17.20	14.22	[a]	[a]	[a]	27.38
48 Cardizem 30mg/tab	0.30	[a]	0.28	0.29	0.29	0.35
49. Lozol 2.5mg/tab	[a]	[a]	0.24	[a]	[a]	0.58
50. Cardizem 60mg/tab	0.46	0.44	0.44	[a]	0.45	0.57

[a]Not reimbursed in October 1991.

[b]Manufacturer provided drug free of charge.

[c]Data not available on Medi-Span.

[d]Average purchase price.

Appendix III

Drug Purchase Prices for Maryland Pharmacies

The following table shows the prices that each of the four pharmacies—one hospital outpatient pharmacy (MHP 1) and three nursing home pharmacies (MNH 1, 2, and 3)—paid per unit for those drugs on the state Medicaid program's top-50 list of outpatient drugs for fiscal year 1991. For oral solids, unit prices are listed by tablet, capsule, or pack. For other products, such as inhalers or insulin, the unit price is for the most frequently dispensed size, as indicated. The top-50 drugs are those for which the state Medicaid program reimbursed the most number of prescriptions. The table also shows each drug's average wholesale price (AWP), as reported on Medi-Span for August 1991. The list includes 73 entries due to different prices for various types of packaging for the same drug. Maryland reimburses a slightly higher amount for unit dose (UD) packaging than it does for bulk packaging.

	Product/unit	MHP1	MNH1	MNH2	MNH3	AWP
1.	Zantac 150mg/tab	$0.86	[a]	[a]	[a]	$1.40
2.	Proventil 90Mcg/inhaler 17gm	3.55	[a]	[a]	[a]	19.48
3.	Humulin N/10ml	6.84	[a]	$13.20	[a]	15.71
4.	Prozac 20mg/cap	1.55	$1.53	1.55	[a]	1.83
	Prozac 20mg/cap UD	[a]	[a]	[a]	$1.62	1.87
5.	Calan SR 240mg/cap	0.59	[a]	[a]	[a]	1.08
	Calan SR 240mg/cap UD	[a]	[a]	[a]	0.43	1.13
6.	Seldane 60mg/tab	0.65	[a]	[a]	[a]	0.77
	Seldane 60mg/tab	[a]	0.65	0.66	[a]	0.77
7.	Disp Insulin U-100/needle	[a]	[a]	[a]	[a]	[a]
8.	Dilantin 100mg/cap	0.12	[a]	[a]	[a]	0.14
9.	Compounded prescriptions	[a]	[a]	[a]	[a]	[a]
10.	Procardia XL 30mg/tab	0.84	[a]	[a]	[a]	1.03
	Procardia XL 30mg/tab UD	[a]	0.84	0.99	0.98	1.17
11.	Lanoxin 0.125mg/tab UD	[a]	0.12	0.10	0.12	0.14
12.	Theo-Dur 300mg/tab	0.02	[a]	[a]	[a]	0.22
	Theo-Dur 300mg/tab UD	[a]	[a]	[a]	0.07	0.30
13.	Tegretol 200mg/tab	[a]	[a]	[a]	[a]	[a]
	Tegretol 200mg/tab UD	[a]	[a]	[a]	0.13	[b]
14.	Bactroban 2% ointment/1gm	0.69	0.69	0.69	0.73	0.83
15.	Dilantin 100mg/cap UD	[a]	0.08	0.15	0.15	0.18
16.	Lanoxin 0.125mg/tab	0.06	[a]	[a]	[a]	0.07
17.	Tylenol #3/tab	[a]	[a]	[a]	[a]	[a]
18.	Dyazide 25 50/cap	[a]	[a]	0.29	[a]	0.32
	Dyazide 25 50/cap UD	[a]	0.26	[a]	0.29	0.33

(continued)

	Product/unit	MHP1	MNH1	MNH2	MNH3	AWP
19.	Lanoxin 0.125mg/tab	a	a	a	a	a
20.	Zantac 150mg/tab UD	a	1.25	1.22	1.23	1.42
21.	Mevacor 20mg/tab	1.50	a	a	a	1.84
	Mevacor 20mg/tab UD	a	1.50	1.50	a	1.88
22.	Tenormin 50mg/tab	0.63	a	a	a	0.78
	Tenormin 50mg/tab UD	a	0.56	a	0.60	0.78
23.	Polymox 250mg/5ml	0.01	a	a	a	0.10
24.	Carafate 1gm/tab	0.47	a	a	a	0.58
	Carafate 1gm/tab UD	a	0.56	0.57	0.58	0.67
25.	Cipro 500mg/tab	2.29	a	a	a	2.71
	Cipro 500mg/tab UD	a	2.37	2.39	2.42	2.80
26.	K-Dur 20meq/tab	0.01	a	a	a	0.29
	K-Dur 20Meq/tab UD	a	0.15	0.18	0.19	0.31
27.	Cardec-DM syrup/120ml	1.10	a	a	a	2.18
28.	Vasotec 5mg/tab	0.65	a	0.66	a	0.80
	Vasotec 5mg/tab UD	a	a	a	0.72	0.83
29.	Atrovent/inhaler 14gm	17.55	13.95	14.37	15.96	21.44
30.	Lotrisone cream/1gm	a	a	0.37	0.53	0.61
31.	Polymox 125mg/5ml	0.01	a	a	a	0.05
32.	Capoten 25mg/tab	0.46	a	a	a	0.56
	Capoten 25mg/tab	a	a	a	0.49	0.57
	Capoten 25mg/tab UD	a	0.52	0.49	a	0.59
33.	Cardizem 60mg/tab	0.46	a	a	a	0.57
	Cardizem 60mg/tab UD	a	0.61	0.52	0.53	0.64
34.	Xanax 0.25mg/tab	0.35	a	a	a	0.48
	Xanax 0.25mg/tab UD	a	0.39	0.42	0.44	0.53
35.	Halcion 0.25mg/tab	a	a	a	a	a
	Halcion 0.25mg/tab UD	a	a	0.48	0.50	0.60
36.	Ventolin 90Mcg/ inhaler 17gm	a	6.13	8.19	a	19.48
37.	Naprosyn 500mg/tab	0.87	0.87	0.90	a	1.06
38.	Nitro-Dur 0.4mg patch/1	0.01	0.30	0.02	a	1.35
	Nitro-Dur 0.4mg patch/1	a	a	a	1.00	b
39.	Ortho-novum 777/pack-28 tabs	0.85	a	a	a	b
40.	Disp. u-100 lo dose 0.5ml/needle	0.07	a	a	a	b
41.	Nitro-Dur 0.2mg patch/1	0.01	0.30	a	a	1.21
	Nitro-Dur 0.2mg patch/1	a	a	a	0.89	b
42.	Naprosyn 375mg/tab	0.71	a	a	a	0.84
	Naprosyn 375mg/tab UD	a	0.71	0.74	0.77	0.89
43.	Nitrostat 0.4mg/tab	a	a	a	a	a

(continued)

	Product/unit	MHP1	MNH1	MNH2	MNH3	AWP
44.	Propoxy 100-650/tab	[a]	[a]	[a]	[a]	[a]
45.	Iletin I NPH/10ml	[a]	[a]	[a]	[a]	[a]
46.	Feldene 20mg/cap	[a]	[a]	[a]	[a]	[a]
	Feldene 20mg/cap UD	[a]	1.75	[a]	[a]	2.18
47.	Xanax 1mg/tab	[a]	[a]	[a]	[a]	[a]
48.	Micronase 5mg/tab	[a]	[a]	[a]	[a]	[a]
	Micronase 5mg/tab UD	[a]	0.23	[a]	0.24	0.49
49.	Klonopin 0.5mg/tab	[a]	[a]	0.47	0.48	0.55
50.	Roxicet 5/325/tab	0.06	0.05	[a]	[a]	0.14

[a]Not reimbursed in October 1991.

[b]Data not available on Medi-Span.

Appendix IV

Major Contributors to This Fact Sheet

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